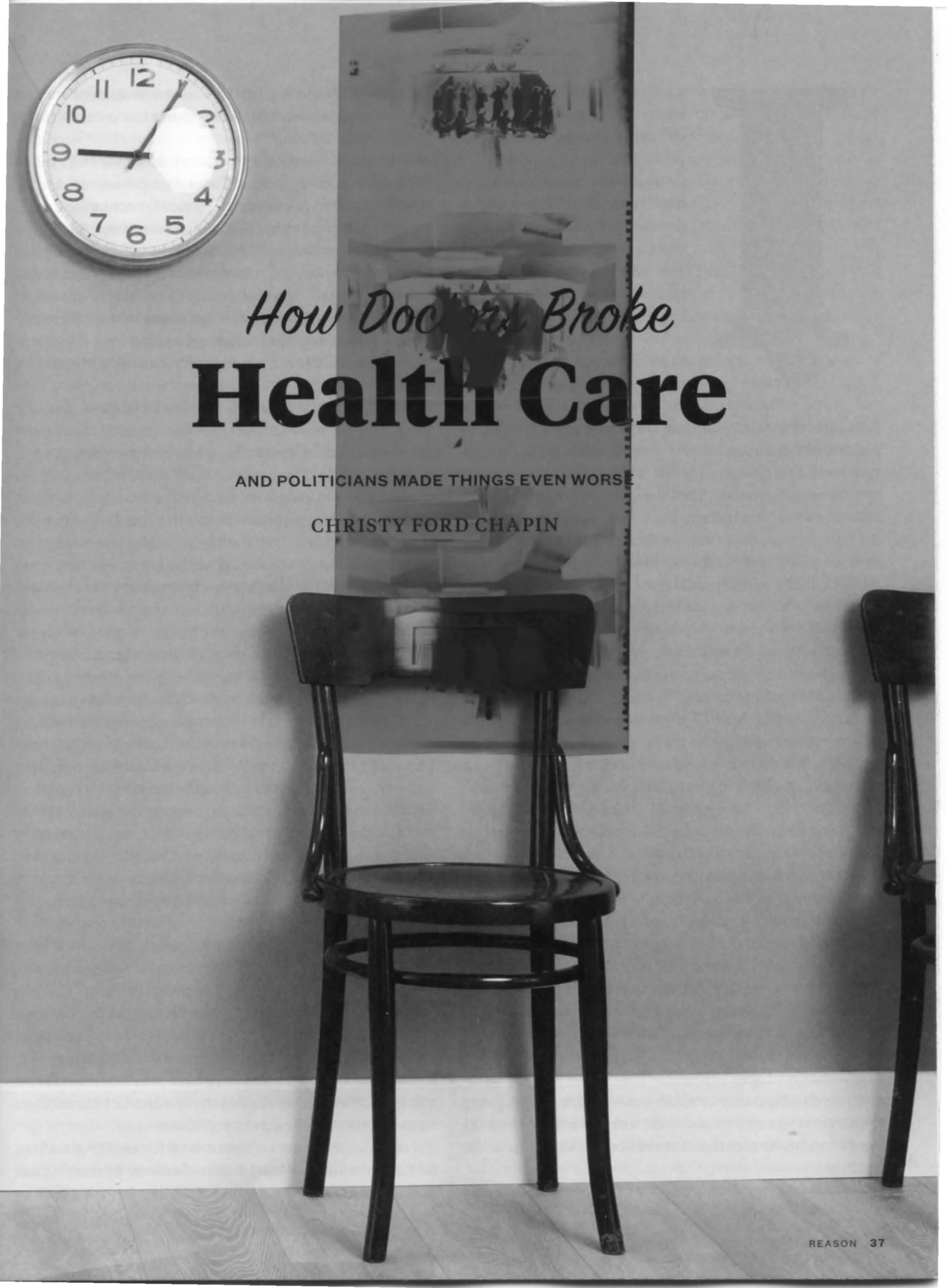
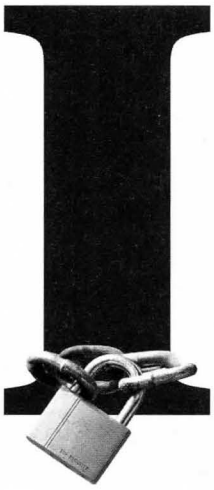


How Doctors Broke Health Care

AND POLITICIANS MADE THINGS EVEN WORSE

CHRISTY FORD CHAPIN



IF THERE'S ONE thing that almost everyone in America can agree on, it's that the health care system is broken.

Nearly 18 percent of America's economy is devoted to spending on health care, far more than the share in any comparable country. And although the U.S. medical system provides some of the best health care in the world, it does so only for those who can afford it. Moreover, fragmented service delivery undercuts overall quality. A decade after passage of the Affordable Care Act (ACA), health care spending is still eating up government and household budgets, nearly 28 million Americans remain uninsured, and costs continue bounding upward.

It's no wonder that health care was the top priority for voters in the 2018 elections or that debates over how to fix it dominated the 2020 Democratic primaries. On one side of those debates were candidates such as former Vice President Joe Biden and former South Bend, Indiana, Mayor Pete Buttigieg, who want to alter the ACA by adding a public option. On the other side were candidates such as Sens. Bernie Sanders (I–Vt.) and Elizabeth Warren (D–Mass.), who favor scrapping the current system and replacing it with a single, government-run program they call Medicare for All. Meanwhile, the Trump administration has declined to defend the 2010 health care law in court and promised to replace it (though the president won't say with what).

These proposals misdiagnose what ails the U.S. health care system because they ignore its history. Too many of today's policy "solutions" build upon the faulty insurance company model that currently organizes U.S. health care—a model that was concocted by the American Medical Association (AMA) in the 1930s as a way to protect the professional status and earning power of its members. It resulted in care that is expensive, bureaucratic, and frustrating for both patients and caregivers.

Some versions of Medicare for All would eliminate private insurers. However, the resulting program, though free from corporate power, would retain the same organizational model, with a government agency assuming the role previously played by insurance companies. Bad institutional incentives would largely remain intact.

The history of health care—both before and after the introduction of the insurance company model—shows how aligning the economic incentives of doctors with the needs of patients can deliver health care that is cost-effective, widely available, and humane.

THE HEALTH INSURANCE model we know today came about after physicians' professional stature began to rise at the end of the 19th century.

With the discovery of germ theory, medicine and medical procedures such as surgeries became safer and more effective. Innovative treatments proliferated. Doctors capitalized on their enhanced cultural standing to convince state legislatures to either pass or strengthen licensing laws. Along with AMA-backed reforms that helped reduce the number of medical schools, licensing laws significantly limited the quantity of practicing doctors. Women, African Americans, and the working class were disproportionately excluded from the doctoring profession and consigned to lower-level medical positions, such as nursing.

With the supply of doctors restricted and the demand for increasingly effective medical services growing, health care prices rose. During the 1920s, an ailment that required a hospital stay could easily consume 10 percent of a family's annual income. Increasing prices only lightly constrained demand, since patients highly valued services that could either improve their quality of life or determine whether or not they lived. Still, families found it difficult to budget for health care because of the unpredictable nature of illness, both in occurrence and cost.

These developments inspired a variety of groups to come up with new ways to organize health care. For example, during the first decades of the 20th century, the nation had thousands of mutual aid societies, also known as lodges or fraternal orders. While some lodges—like the Order of Elks—originally restricted membership to native-born white males, immigrants and African Americans established their own societies. Immigrant organizations ranged from the Venetian Fraternal Union (serving Italian Americans) and the Independent Order of Vikings (serving Swedish Americans) to the First Serbian Benevolent Society and the Chinese Consolidated Benevolent Association. They functioned as social clubs, usually with distinctive uniforms and regalia. At the local lodge, bar, or church where they met, immigrants could speak their native language and share food from their home country. Fraternal orders also offered members, in return for regular dues payments, financial security products. Most supplied life insurance. Many contracted with physicians and hospitals to provide medical care.

African Americans created a massive network of these associations, some of which evolved into black-owned insurance companies and banks. One such society in Mississippi—the Order of Twelve Knights and Daughters of Tabor—constructed a hospital. Dues-paying members received burial insurance and up to 31 days of medical and surgical care.

Labor unions also furnished health care for members. In 1913, the International Ladies' Garment Workers' Union (ILGWU) founded a clinic in New York City. In exchange for a

small fee, members—who also helped run the clinic—could access both medical and dental services. During the 1930s, the Transport Workers Union contracted with more than 50 doctors, including specialists, to provide members with care both in the doctor's office and in the hospital.

Businesses experimented with medical care provision as well. While factories hired doctors to run on-site clinics, "industrial medicine" flourished as a specialty. To stave off bad publicity for their employers, industrial physicians monitored the workplace for ways to prevent injury and disease. They also weeded out the chronically ill from job applicant pools. Some businesses contracted with outside medical providers. During the 1920s, the Endicott Johnson Corporation, a shoe manufacturer in upstate New York, spent about $22 annually for each worker and his or her family to access physician, hospital, and dental services.

Consumer cooperatives were another vehicle of delivery. In 1931, Dr. Michael Shadid established such an organization in Elk City, Oklahoma. For an initiation fee and annual payment, patients could access both physician and hospital services. Subscribers also elected a board of directors to operate the plan. During the Great Depression, Farm Security Administration officials helped farmers' organizations establish similar cooperatives around the country.

Nor were doctors passive participants in the health care sector's wave of organizational innovation. By the early 1930s, they had founded hundreds of prepaid physician groups, which delivered high-quality care in a cost-effective manner. Two features distinguished them from today's physician groups.

First, they were multispecialty. This format offered patients "one-stop shopping" for comprehensive care, ranging from general practice and surgical to obstetric and ophthalmological services. But integrated care offered more than convenience—it improved service quality. In today's health care system, patients with multiple conditions or difficult-to-diagnose illnesses often consult a variety of physician specialists in separate practices. Although general practitioners theoretically coordinate the patient's overall care, in reality, most physicians lack the time to confer regularly with colleagues outside their practice. In contrast, early prepaid groups had responsibility for the patient's entire health profile. These group doctors met regularly to discuss how to treat difficult cases. Patients received holistic care, while physicians had more opportunities for creative problem solving and for learning across medical specialties.

The second distinctive feature of these doctor groups was that they were "prepaid." In the early 20th century, *prepaid care* was synonymous with health insurance. Accordingly, the prepaid doctor group acted as its own financing or insurance unit. Individuals and families paid a set monthly fee in exchange for unlimited services. Physicians who worked for prepaid groups typically earned a salary plus a portion of the group's quarterly profits. These financing arrangements motivated physicians to both hold down costs and provide high-caliber care.

Examining how present-day financing systems incentivize physicians to behave illuminates the elegance of prepaid group arrangements. Rather than directly financing care themselves, today's doctors are usually compensated by third parties, either governments or outside insurers.

In health care systems around the world, one of two problems almost always occurs: Either medical providers ration care, or they practice "overutilization," a fancy term for the delivery of unnecessary and wasteful services and procedures.

Where physicians earn a set salary—as do British doctors or American physicians who work for closed-panel HMOs like Kaiser Permanente—a primary patient complaint is that care can be difficult to obtain. Doctors seem reluctant to greenlight treatments, because their employers encourage them to ration care and because more services and procedures mean more work without additional pay. Moreover, these arrangements often produce lower-quality care, though the degree of this problem depends on additional economic conditions, such as whether the financier is a government monopoly or a firm competing against other insurance companies. (Similar complaints arise when doctors receive set per-patient "capitation" fees.)

With fee-for-service systems, in which each discrete treatment or action results in a payment from the insurer to the doctor, overutilization and rising costs are always among the drawbacks. Currently in the U.S., most insurance companies reimburse doctors on this basis, thereby encouraging them to oversupply care. It's not that physicians are particularly malevolent. It's that they respond to financial incentives just as carpenters, mechanics, lawyers, and, yes, even professors and journalists do.

Imagine renting an office, purchasing equipment, hiring a bevy of administrators to keep up with mountains of government and insurance company paperwork, and working 10- to 12-hour days knowing you'll be paid only if you bring in enough money to cover both overhead expenses and your salary. If Medicare and insurance company reimbursements (less than half of doctors accept Medicaid patients) were not enough, might you be tempted to find additional revenues not by "running up the bill," as we might see it, but by "providing my patients with the same gold standard treatment that I'd want my own family members to receive"? Perhaps?

In contrast to current financing arrangements, prepaid physician groups aligned the doctor's pecuniary self-interest with the patient's desire for quality care. They carefully balanced resource expenditures between rationing and overutilization. Remember: Group physicians collectively assumed the financial risks associated with insuring patients against the costs of

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illness, and group doctor compensation derived from a portion of the organization's total profits. On one hand, if group doctors delivered poor-quality care or rationed services, they earned less. Patients who became sicker would consume additional resources, and dissatisfied customers would discourage new subscribers from joining. On the other hand, if group physicians supplied unnecessary services and procedures, they reduced their pay by frittering away group resources.

Because they offered reasonably priced insurance and excellent care, prepaid physician groups were popular with consumers. In 1929, Drs. Donald Ross and Clifford Loos started just such a group in Los Angeles. Members paid a monthly fee plus a small deductible at the time of service. Benefits were generous. The Ross-Loos plan offered prenatal and delivery care well before insurance companies would even consider covering such high-cost benefits. Within six years of its founding and during the Great Depression, the Ross-Loos practice grew to staff 50 doctors and serve approximately 40,000 patients. Most prepaid groups contracted with hospitals for admitting privileges. Because of its size, the Ross-Loos practice had its own pharmacy, laboratory, medical library, and ambulatory surgery facility.

Progressive political thought burgeoned at the end of the 19th century and continued to influence policy makers through the New Deal era—and progressive reformers admired prepaid doctor groups. Progressives not only had respect for but were practically obsessed with expertise, scholarly studies, statistics, and facts piled high. The Committee on the Costs of Medical Care (CCMC), which operated during the late 1920s and early 1930s, embodied this impulse. Academics, leading physicians, public health officials, political reformers, and scholars associated with nonprofit foundations studied a variety of health care models, ultimately recommending the propagation of prepaid doctor groups. Progressive CCMC members recognized the model's organizational efficiency and wished to position it at the core of a government-financed health care system.

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Today's progressives might protest, asserting that they too believe in expertise; after all, most academics stand among their ranks. But today's health care debates, rather than addressing fundamental economic and organizational issues, unfold largely as morality tales, pitting "good guys" against "bad guys." (Note that the "bad guys" in this telling—policy makers who either oppose reform or are proposing minor repairs—also fail to recognize the health care system's structural frailties.) Some contemporary reformers underscore the administrative savings they believe will result from the centralized management of health care. Others offer budget forecasts that, like the Knights of the Round Table, are notoriously fictitious. But what's missing are discussions of how to configure institutions and structure provider and patient incentives to ensure accessibility, quality, and cost-effectiveness.

SO WHAT HAPPENED to prepaid doctor groups and the health care models sponsored by mutual aid societies, unions, businesses, and consumer cooperatives? In sum, AMA leaders captured and reconfigured the market to serve their own ends.

Through the first decades of the 20th century, the American Medical Association marshaled its considerable power to shut down and halt the spread of "alternative" health care organizations. Physician leaders believed they threatened their professional autonomy and pay. Worried about interference in "their" sphere of medicine, AMA officials even opposed health insurance because it allowed groups external to the doctor-

patient relationship to finance care. They also feared that physician groups would develop into corporations that would commercialize health care and produce "supermarket medicine."

Accordingly, AMA leaders waged war against physicians who contracted with or worked for "third parties," whether mutual aid societies or doctor groups. Since AMA members controlled state licensing boards during this period, they could revoke the medical licenses of transgressing doctors. For example, AMA officials warned physicians that working for Shadid's cooperative would jeopardize their medical licenses. Organized physicians also exercised a great deal of control over hospitals, and they frequently persuaded administrators to rescind the admitting privileges of doctors who ran afoul of AMA preferences.

Additionally, medical societies often expelled members who worked with third parties. The L.A. County Medical Association, a constituent AMA society, dismissed Drs. Ross and Loos. Physicians who lacked medical society membership had difficulty obtaining malpractice insurance, ostensibly because they lacked colleagues to testify on their behalf.

Although AMA leaders had great success suppressing the health care market's organizational evolution, their feat only amplified calls for government funding to increase access to services. As policy makers experimented with programs to improve economic conditions during the Great Depression, health care was a leading reform target. Committee on Economic Security (CES) members, who laid the cornerstone of the American welfare state with the 1935 Social Security Act, initially hoped to include government-financed medical care in the legislation. President Franklin Roosevelt—savvy politician that he was—rejected their plan, understanding that hundreds of AMA medical societies could lobby congressional members to sink the entire bill. But his administration continued to eye health care reform, and at the end of the decade it held a national conference to spotlight the issue.

Unable to fight a two-front conflict—on one side against competitive markets, and on the other side against government-financed medicine—AMA leaders concocted a new strategy. In 1938, they finally endorsed health insurance. Yet they continued battling the insurance models that the market had already produced, such as prepaid benefits delivered through consumer cooperatives and doctor groups. Instead, AMA leaders designed their own, very particular insurance model. They then promoted their specific model under the banner of the "voluntary" market—that is, the alternative to government programming, which they cast as communism.

The AMA's brainchild—the insurance company model that organizes our health care system today—permitted only one type of third party to finance medical services: insurance companies, not mutual aid societies, unions, or even doctor groups. The association's leaders instructed insurance companies to fund individual physicians rather than group practices and to reimburse physicians on a fee-for-service basis—a payment method that, as discussed, guaranteed overutilization and escalating costs. (Initially, physicians even set their own compensation fees, until insurers implemented standardized fee schedules between the 1950s and 1970s.) AMA parameters also required complete physician autonomy, free from insurer supervision.

Recognizing that it would drive up health care prices, insurance executives were wary of the AMA's proposed model. Insurers had little desire to finance services if they could not control, supervise, or even forecast the supply of those services. But they gave in to AMA wishes because they wanted to combat nationalized medicine and because their business clients—to whom they sold life insurance and pension products for workers—had been clamoring for employee health insurance. Federal tax guidelines granted employers a hefty tax break for providing workers with fringe benefits beyond monetary compensation. Plus, employer-provided health insurance weakened labor organizing by making businesses, not unions, the stewards of workers' financial security.

Though mistrustful of one another, physicians and insurers joined together to hurriedly develop the health care sector around the insurance company model. AMA officials and insurance executives continually and forcefully argued that government provision of health care was unnecessary because the "voluntary" insurance sector was thriving. Quite remarkably, they grew coverage quickly enough not only to rebuff Harry Truman's plan for universal health care but also to defeat moderate reform proposals proffered by President Dwight Eisenhower and a variety of bipartisan congressional alliances. Between 1945 and 1965, the share of the populace covered by health insurance increased from approximately one-quarter to 80 percent.

Predictably, under the insurance company model, health care costs shot upward in tandem with expanding coverage rates. Physicians and insurers responded by building institutions to manage their financing relationship.

Although physicians adamantly resisted insurance company regulation, AMA officials begrudgingly relented in response to the negative publicity surrounding medical costs. A 1950s Blue Cross study revealed that approximately 30 percent of hospital admissions were unwarranted. Hospitalization allowed doctors to deliver patients more tests and procedures than were available in a physician's office. During the same decade, the press uncovered a trend of unnecessary surgeries. Pathologists discovered, for example, that in some hospitals more than half the appendectomies performed were unneeded. Although overt fraud was worrisome, insurers were more concerned with small accretions of overutilization, both inside and outside the hospital. Such services were difficult to detect but,

when aggregated, pushed insurance prices significantly higher.

Insurers responded by instituting cost containment measures. Gradually, over the course of decades, they gained the power to supervise doctors and influence how medicine is practiced. During the 1950s, they began carefully monitoring physician services through medical forms. By the 1960s, physicians often needed to obtain insurance company permission to admit patients to hospitals. Insurers also worked with medical societies and hospitals to establish utilization review committees, which examined whether physician services properly matched the patient's diagnosis. Insurers collected data from these committees to create standardized treatment blueprints: In return for compensation, doctors had to accept insurance company instructions on patient care. Despite these cost-containment efforts, health care expenditures, as a percentage of our nation's GDP, have grown each decade since the 1950s.

Though health care reformers had long attempted to dislodge the insurance company model, they surrendered that fight by the 1960s. As Social Security Administration officials and their allies developed a plan for government-provided retiree health care, they realized that they had to construct the program around the institutions that were already being used to manage service financing and delivery. They therefore designed Medicare to incorporate the insurance company model. Policy makers also appointed insurance companies to administer Medicare by acting as intermediaries between federal officials and service providers—doctors and hospitals.

The ACA also adopted the insurance company model. Although progressive legislators attempted to subvert the model with the "public option"—a government-run insurance plan that would operate alongside today's private insurance—that provision was ultimately defeated. And the public option, as proposed in today's health care debates, is unlikely to undermine the insurance company model to the same degree as initially projected, because state exchanges have not appropriated as much of the health care system as policy makers and analysts originally planned.

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THIS CHECKERED HISTORY helps explain the frustrating state of the U.S. health care system today. It shows why care is fragmented and costs are high—the highest in the world as a percentage of GDP. And it demonstrates that the country's health care system, including the so-called "private sector," is not based on the evolution of competitive markets. Instead, the model sprang from the minds of physician leaders seeking to safeguard their professional status and earning power. Ironically, the arrangements they designed have developed in a way that undermines those very goals. Today's system is largely controlled, in a top-down manner, by insurance companies.

Finally, this account reveals how our current health care debates are neglecting the most vital aspects of reform. To fix our system—that is, to provide better care while getting rid of unending and unsustainable cost increases—we must consider how to structure institutions to operate effectively without Washington bureaucrats supervising and controlling medical care. Insurers can tell them that such an approach to cost containment is futile. And cost control purely through budget constraints, without attention to institutional incentives, will only lead to rationing.

Direct Primary Care (DPC) physicians are beginning to reclaim their heritage by approximating the prepaid doctor groups of the early 20th century. Seen as a low-cost alternative to concierge care, DPC groups accept monthly membership fees in lieu of insurance. In return, they

provide patients with extended physician visits, lab and diagnostic tests, and—in states where doctor groups are permitted to purchase drugs at wholesale costs—reduced-priced prescription medications. They have had excellent success in terms of cost containment and care advancements, such as increased doctor-patient communication through phone and email conversations.

DPC promoters often speak of physicians' desire to escape the "eight-minute consultation" and the burdensome volume of insurance regulations and paperwork. The American Academy of Family Physicians even sells a "DPC Toolkit."

However, these groups are single-specialty, revolving around general practitioners. If they do develop into multispecialty practices that deliver comprehensive care, they'll have to negotiate with hospitals for patient admissions and facility usage. And that process will take some time to evolve.

One can envision the innovations that might ensue under such a system. Imagine doctor groups catering to elderly patients with appointment pickup vans or offering free nutrition classes for diabetic and overweight patients.

DPC is neither a silver bullet nor the only way to reform health care. But the model does demonstrate that reformers must look at the health care system's economic structure to understand how all actors—physicians, hospital administrators, patients, and third-party financiers—are incentivized to behave.

In many ways, that would represent a return to traditional progressive ideals, from the institutional efficiency that reformers promoted in the early 1900s to the participatory democracy—or empowering of local communities—they advocated in the 1960s. As we debate how to make health care more accessible and affordable, we should emphasize institutions that can evolve on the ground, in response not to special interest groups or to federal officials but to the unique needs of patients. From the elderly Latino couple in San Antonio dealing with the effects of aging to the young black woman suffering from breast cancer in New York City, it's the patients with the least economic and political power who will bear the brunt of our health care system's failings—whether their care be costly and difficult to afford or inexpensive but rationed. ●

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